Florida Hospital and UCF Health
Open a Gateway to Better Health in Lake Nona
Care that’s wrapped around your patients

A brand new medical gateway is now open in Lake Nona! Gateway is a revolutionary concept created with a shared vision of innovation and access to the latest health care options. Through collaboration in medicine and education, we are providing an array of prevention, diagnosis and treatments for the body, mind and spirit.

Together, we’re creating a gateway to better health.

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I am pleased to bring you another issue of *Florida MD*. I had the pleasure of working with the Ovarian Cancer Alliance of Florida (OCAF) for several years as a member of its board of directors. I used the time as a way to honor my mother who passed away because of complications from ovarian cancer. They recently widened their focus and changed their name to **The Women’s & Girls’ Cancer Alliance (WGCA)**. Please join me in supporting this truly wonderful organization and their fight against gynecologic cancers.

Best regards,

Donald B. Rauhofer
Publisher

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Every year over 86,000 women and girls are diagnosed with a gynecologic cancer. About 30% of them will die because of late-stage diagnosis and the aggressiveness of these diseases. **The Women’s & Girls’ Cancer Alliance (WGCA)** has been there for women in Central Florida for nearly 20 years to offer support and education in hopes that the outcome will be different for the next woman who hears, “You have cancer”.

WGCA’s Making the Rounds program collaborates with healthcare providers to educate and empower women and girls with the knowledge and confidence necessary to take control of their gynecological health. This is accomplished by providing patients informational tools such as brochures and symptom diary cards in their physician’s lobby.

Patients are also connected to WGCA’s gynecological cancer network of survivors for mentorship and social support. Dr. Robert Holloway, Gynecologic Oncologist at Florida Hospital Cancer Institute in Orlando, recognizes the stress reducing effects of WGCA’s network of survivors, “WGCA is the most impactful resource for women newly diagnosed with a gynecologic cancer. The knowledge and experience they generously share with our patients significantly relieves stress and enhances their recovery.”

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**COMING UP NEXT MONTH:** The cover story focuses on University Behavioral Center. Editorial focus is on Allergies and Sleep Disorders.
Florida Hospital and UCF Health have joined forces to offer residents of Lake Nona and surrounding communities an exciting new option for their primary and specialty health care needs. This latest addition to Medical City, housed in a gleaming new glass building on Narcoossee Boulevard, is a one-stop location where patients can access the physicians, imaging technology, physical therapy services and on-site lab facilities of two of Central Florida’s leaders.

Billed as a revolutionary model for health care delivery, this new medical gateway combines the clinical expertise, academic excellence and groundbreaking research of physicians affiliated with Florida Hospital and UCF Health, the College of Medicine physician practice. This unique endeavor is aimed at promoting collaboration among health professionals and setting a new benchmark for convenient, quality care. Visitors will have access to primary care doctors and specialists in a wide range of fields, including family medicine, adolescent medicine, internal medicine, rheumatology, urology, and men’s and women’s health—with additional specialists soon to be added in the fields of cardiology, dermatology, endocrinology, gastroenterology, obstetrics and gynecology, orthopedic surgery, and sports medicine.
Two leaders in healthcare and education, Florida Hospital and UCF Health, have partnered to create a gateway to better health in Orlando’s emerging Medical City. Their shared location is an innovative and collaborative model of healthcare that brings a range of new physicians and services to Lake Nona.

This unique partnership allows patients convenient access at a single location to UCF Health and Florida Hospital’s physicians, imaging service, physical therapy and laboratory services. At the same time, patients can also tap into the academic strength of the UCF College of Medicine’s practice, where all doctors are faculty physicians at the medical school.

It is with a shared vision that Florida Hospital and UCF Health created this unique gateway, which integrates clinical services, wellness, education and research. UCF Health and Florida Hospital physicians include primary care doctors and specialists in a variety of areas, such as
family medicine, internal medicine, rheumatology, urology, adolescent medicine, men's health, and women's health. Additional specialties coming soon include: cardiology, endocrinology, orthopedic surgery, sports medicine, gastroenterology, dermatology, obstetrics and gynecology.

Florida Hospital’s onsite imaging center gives patients a convenient option for advanced diagnostic technology for their mammograms, DXAs, ultrasounds, X-rays, MRIs and CT scans. At Florida Hospital’s onsite rehabilitation center, patients can receive treatment from physical therapists who specialize in sports medicine, spine and other areas. In addition, patients have instant access to Florida Hospital’s laboratory for physician-ordered clinical tests.

**COLLABORATION OF CARE AND CONNECTIVITY**

The emphasis on collaboration extends into other areas, such as clinical data sharing, education and research. Through a coordinated care model, patient records are shared between providers through a secure Health IT system. Another distinction is the physicians’ workspace. Instead of working in silos at their private offices, physicians literally work together in an open space, which allows for open and collaborative care. This is a model for medical practices of the future, and a perfect fit for Lake Nona, where technology and innovation are cornerstones of the community.

“Our focus is keeping the patient at the heart of all we do, which extends beyond a single episode of care. It’s about creating lifelong relationships with each patient – knowing and meeting their individual needs,” said Terry Owen, Senior Vice President at Florida Hospital. “It’s what we call Connected Care – creating the optimum patient experience by providing convenient, coordinated, comprehensive care.”

**A TEAM APPROACH TO HEALTHCARE**

At this new destination for health, Florida Hospital Medical Group provides easy access to primary and specialty care. Dr. Amit Desai, board-certified family medicine physician, ap-
Amit Desai, MD, is a board-certified family medicine physician who applies his advanced clinical skills along with the latest diagnostics and treatments for every member of the family.
UCF’s College of Medicine has helped lead innovation at Lake Nona, with a 21st century medical school that features state-of-the-art labs and classrooms and a new curriculum that integrates basic and clinical sciences from a student’s first year. Many UCF faculty physicians also are researching new and better treatments for disease. The Lake Nona location is the second for UCF Health (previously UCF Pegasus Health), which opened its first center in 2011 on University and Quadrangle Boulevards, just blocks from the main UCF campus.

“We are thrilled to expand our multispecialty practice to serve more people across our community,” said German. “We are happy to partner with Florida Hospital to bring needed outpatient care to our Lake Nona neighbors.”

THE GATES ARE OPEN

Together, Florida Hospital and UCF Health have created a gateway to better health through innovation and collaboration—bringing the latest in medicine and education to Lake Nona. Through collaboration and a shared vision of improving access to health care options, our unified team offers primary and specialty care, imaging, lab services and physical therapy—all in one location. The comprehensive care provided, coupled with groundbreaking medical research, ensures the most advanced prevention, diagnosis and treatment for the body, mind and spirit.

Gateway Lake Nona is conveniently located at Tavistock Lakes Boulevard and Narcoossee Road in Orlando. The center is accepting new patients of all ages, and most major insurance plans are accepted.

CONTACT INFORMATION:
9975 Tavistock Lakes Blvd., Orlando, FL 32827
To learn more, call 407.930.7800 or visit GatewayLakeNona.com.
Beware of Nurse Practitioners Bearing Gifts: The Approved Protocol Does Not Protect The Unwary, It Can Happen To You!

By Joel Hirschhorn, Esq. & Alexander Strassman, Esq.

You’ve made a bad investment which has become a money drain. You are planning for the future. Private school, college investment programs for your children. The profitability of your medical practice is getting thinner and thinner. Instead of working just 60 hours a week, you are now putting in 75-80 hours. Fourteen-hour days are the norm. Financial pressure builds up. You are overextended, overworked, underpaid. The Perfect Storm is brewing.

Along comes an independent—even respected and qualified—nurse practitioner (NP). H/she has proposed that for what appears to be a tempting sum of money—perhaps as little as $1,250.00 a month—you can “supervise” the NP, provide very little actual medical “service,” review and sign off on charts and “orders” and pick up a little “pocket” change. The naïve and unsuspecting: Beware.

Federal criminal prosecutions have become the key tool used in the Government’s war seeking to ensure that Medicaid and Medicare programs are not financially abused.

Physicians play a central role in a complex industry that is heavily reliant upon taxpayer funding of these Federal programs. Abuse—both intentional and unintentional—has become rampant. Federal law comes into play when physicians ask Uncle Sam to pay the bill for health services. These Federal programs define the “acceptable” degree of supervision by doctors and nurses or physician’s assistants. Even more frequently the doctor is totally unaware that the supervision required by Federally funded programs is far more rigorous than that required under State law.

The reality is that no one person can do everything. When tasks need to get done in any complex workplace or organization, responsible delegation is key. The President has trusted advisors, cabinet members and staff. The corporate executive may have scores of assistants and employees upon whom he or she relies. The senior law partner has junior partners, associates, paralegals and secretaries who are trusted to get the job done correctly and ethically.

The healthcare industry ought not be any different. But, it is. Healthcare is both a noble calling and a business after all, though many often do not think of it that way. Physicians routinely rely upon NP’s to assist in diagnosing patients and administering treatment. Trained billing coders input the data needed to ensure payment for services rendered. Florida’s Administrative Code appears to require “general” supervision for many aspects of delivering medical services. NP’s are authorized to handle certain healthcare issues so long as the supervising physician is within a specified “proximity” (whatever that means) of the location, and “available” for consultation (whatever that means). Other aspects of the medical practice require more direct supervision, where the doctor must be physically present and more actively involved in administering or supervising the care given.

As we all know, when things “go wrong,” the supervisor often takes the blame—regardless of how blameworthy s/he truly is. Political heads resign as a result of employee-centered scandals. Lawyers are disbarred when long-trusted secretaries or bookkeepers steal from the attorney’s escrow account.

It is the same in the healthcare sector. Poor judgment can cost a doctor not only his or her medical license, but also one’s reputation, hard-earned assets and even liberty. Though it may come as a shocking surprise, the harsh reality is that well-intentioned, unwitting doctors who “sign off” on patient charts can be held responsible under Federal criminal law for the fraudulent conduct of those they supervise—even if that conduct appears to be consistent with the doctor-nurse protocol filed with, and approved by, the Florida Department of Health.


Joel Hirschhorn is a shareholder at GrayRobinson and a member of the Criminal and White Collar Defense team. He can be reached at joel.birschhorn@gray-robinson.com or 305-416-6880. Alexander Strassman is an associate at GrayRobinson and a member of the Criminal and White Collar Defense team. He can be reached at alex.strassman@gray-robinson.com or 305-416-6880.

COMING UP NEXT MONTH: The cover story focuses on University Behavioral Center. Editorial focus is on Allergies and Sleep Disorders.
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Blood Testing for Noninvasive Assessment of Pulmonary Nodules

By Daniel T. Layish, MD, FACP, FCCP, FAASM

With the frequent use of CT scans, incidental findings of lung nodules are a common problem. Clearly, some of these lung nodules are eventually found to represent early lung cancers. However, most will wind up being benign. PET scan can be helpful in the evaluation of lung nodules, but only when they are above 10 mm in size. In addition, PET scan is expensive. PET scan does have a false positive rate typically felt to be between 12 and 20%. Bronchoscopy is invasive and may not be helpful in the evaluation of very small lung nodules. In addition, bronchoscopy can result in complications such as bleeding, hypoxia and pneumothorax. CT guided fine-needle aspiration is helpful for peripheral lung nodules. However, this is also invasive and can be associated with complications such as pneumothorax and bleeding. Therefore, it would certainly be helpful to have a blood test that would serve as a tool in the assessment of a patient with a lung nodule found on an imaging study.

There is now a commercially available blood test called Xpresys® Lung. This test uses proteomic technology to measure multiple circulating proteins associated with lung cancer. The blood is analyzed using multiple reaction mass spectrometry. The Xpresys Lung blood test is not affected by age, smoking history, gender, and nodule size or nodule location. It is also not affected by the presence or absence of COPD. Therefore, it provides additional risks stratification above and beyond these clinically evident parameters. When the Xpresys Lung test reveals a high probability of a benign nodule, this may allow the clinician to continue sequential CT monitoring and avoid the need for invasive procedures.

There was a validation study of this technology published earlier this year in the Journal of Thoracic Oncology. This was a retrospective multicenter case control study. Nodules between 8 and 30 mm in size were studied. The researchers found 90% negative predictive value in the study. At this point, the strength of the test appears to be negative predictive value. However, it should be noted that the test has not been evaluated in a prospective study. In addition, it has not been evaluated in a large sample of patients. Therefore, although the test is commercially available, its role in the diagnostic evaluation of lung nodules remains to be completely defined. Nevertheless, it is an option worth being aware of and hopefully will signal the beginning of a new era in the diagnostic evaluations of lung nodules.

Daniel Layish, MD, graduated magna cum laude from Boston University Medical School in 1990. He then completed an Internal Medicine Residency at Barnes Hospital (Washington University) in St. Louis, Missouri and a Pulmonary/Critical Care/Sleep Medicine Fellowship at Duke University in Durham, North Carolina. Since 1997, he has been a member of the Central Florida Pulmonary Group in Orlando. He serves as Co-director of the Adult Cystic Fibrosis Program in Orlando. Dr. Layish may be contacted at 407-841-1100 or by visiting www.cfpulmonary.com.

Be sure and check out our website at www.floridamd.com!
It is estimated **8.6 Million** Americans meet the guidelines for lung screening programs, resulting in an expected increase in benign nodules being identified. Xpresys Lung may be able to assist in more effectively managing these nodules and potentially avoid costly and invasive procedures.

**Why use Xpresys Lung?**
- Vast majority of 8-30 mm nodules are benign
- Potential to reduce unnecessary invasive procedures
- Potential to reduce patient anxiety and stress from CT monitoring

**What is Xpresys Lung?**
- Non-invasive blood test for pulmonary nodules
- Measures proteins associated with lung cancer
- Identifies nodules with a high probability of likely benign (from 84-98%)¹
- For patients with 8-30 mm nodules and >40 years of age

References:

Xpresys and Indi are registered trademark of Integrated Diagnostics, Inc.
Moffitt Cancer Center Achieves Nursing Magnet® Recognition

By Jane Fusilero, RN, MSN

Moffitt Cancer Center is now one of 20 hospitals in Florida that has earned the prestigious Magnet® designation. Magnet designation is the “gold standard” of nursing excellence. It shows that an institution has created a culture of outstanding nursing professionalism, teamwork, quality patient care and innovation in nursing practices. Magnet recognition is granted by the American Nurses Credentialing Center (ANCC), the credentialing body of the American Nurses Association. Today, only 7 percent of national and international health care organizations are recognized by the ANCC Magnet Recognition Program®.

Magnet designation is achieved after successfully completing a rigorous process whereby the ANCC conducts evaluations in the following key areas: Competent, dedicated and skilled nurses; continued innovation within staff knowledge, clinical practice and systemic improvements; empowered staff properly prepared to face all challenges; outcomes measurement systems in place throughout the entire organization; and visionary leadership transforming the organization to meeting changing needs.

The Magnet Model is designed to provide a framework for nursing practice, research and measurement of outcomes. Through this framework, ANCC can assess applicants across a number of components and dimensions to gauge an organization’s nursing excellence. The foundation of this model is composed of various elements deemed essential to delivering superior patient care. These include the quality of nursing leadership and coordination and collaboration across specialties, as well as processes for measuring and improving the quality and delivery of care.

Research shows that Magnet hospitals consistently provide the highest quality of care. The standards that Magnet hospitals must attain through this program are rigorous and demand continual improvement. Nurses at Magnet hospitals consistently outperform non-Magnet organizations with better patient outcomes and report higher patient satisfaction rates. Magnet Hospitals report increased nurse retention and increased rates of job satisfaction. This can only be accomplished with the support and participation of all of the departments and employees in the health system that places the patient first and foremost in the mission of their daily work.

Patients are more actively involved in their medical care and often seek objective benchmarks that will aide them in choosing a health care provider. Magnet designation provides patients and their families with a way to identify hospitals where they can find satisfied nurses and expect to receive a higher level of care.

At Moffitt, nurses are involved with every aspect of patient care and research, from prevention and screening to treatment and clinical trials. Our nurses partner with patients and families as part of our multispecialty team to deliver expert and compassionate care to support Moffitt’s mission: to contribute to the prevention and cure of cancer. Our nursing program includes registered nurses, nurse practitioners and clinical nurse specialists. Many are certified in specialties such as oncology, critical care and radiology. On the clinical side, our nurses work within multispecialty teams to provide consultations, diagnoses and treatment planning, symptom management and follow-up care. Research nurses evaluate, register and coordinate patients in our robust clinical trials. Our nurses also provide education and counseling through the continuum of care.

To learn more about nursing services at Moffitt, visit www.Moffitt.org.

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How to Use Video to Maintain a Personal Touch at Your Practice

By Jennifer Thompson

How can you maintain and create a personal touch by using social videos to promote your practice?

Videos are the fastest growing medium to reach and engage potential patients in the electronic age. The stats are just too hard to ignore. According to a recent Invodo report:

• 74% of all Internet traffic in 2017 will be video
• 52% of marketing professionals worldwide name video as the type of content with the best ROI
• 80% of your online visitors will watch a video, while only 20% will actually read content in its entirety

We hear weekly from clients that patients have chosen to visit a particular doctor or go through with a surgery because of a video they saw created by the practice.

So, what should you be creating videos of at your practice?

GETTING TO KNOW THE DOCTOR(S)

These short, informal videos are an absolute favorite of patients and they are, hands down, one of the best ways to create a personal touch on the Internet for your medical practice.

Physician video biographies are meant to help patients get to “know” their doctor (or potential doctor) prior to coming in for their appointment. Watching can help patients learn about their doctor’s personality, who they are away from the office and make a “personal” connection with their healthcare provider before ever setting foot inside the office.

When done correctly, these videos will help “soften” a patient’s visit and create a loyalty to the doctor and your practice in just under 3-5 minutes.

PATIENT TESTIMONIALS

Time and time again we hear from patients who have decided to have a surgery done after viewing a testimonial on a practice’s website. These things really work that well.

Patient testimonial videos are the gift that keeps on giving because their story will last forever and it helps put a face, not only to the physician the patient is raving about, but to the people your practice helps – people just like those who are in need of your services and looking around online.

Although these videos create a personal touch immediately, there are some key things to be aware of:

• Make sure your patient is well-spoken and isn’t afraid of the camera
• Practice the proper procedure name and pronunciation of the physician’s last name with the patient several times before recording
• Try to schedule videos when the physician is available to show them and the patient interacting
• Start by having your patient introduce themselves and discuss the biggest benefit of the surgery as soon as possible
• Keep your final videos to 3 minutes or less whenever possible

PROCEDURE VIDEOS

The two types of video listed above cover the human element of the practice, but patients and Internet searchers are also interested in what procedures and treatments you offer; and, these make for great original video content as well.

There are several ways to go about creating these procedural videos:
• Purchase animations from a service. These are generally computer rendered and are not personal, however they do a wonderful job explaining the procedure and what is involved.

• Have a physician discuss the procedure. These are more personal and help patients identify and associate a particular doctor with a specific procedure. Capturing the proper footage is difficult and the success depends on the physician.

• Animate a video. Services allow you to animate videos and narrate over them to explain procedures. These are the most difficult to make, although they can create a personal touch as well, second to seeing the physician describe the procedure.

Procedure videos by default are less personal than some of the other video methods, but they still serve a purpose from a patient education and SEO perspective and therefore should not be ignored.

OFFICE TOURS

Video or photo tours of your office(s) work well as another way to “soften” the initial visit for patients. By viewing your office beforehand, patients are more comfortable scheduling their appointment.

There are two real methods to create office tours:

• Use photos and edit them together to create a montage or slideshow

• Take short clips of your office and edit them together as in the example below

Although the photo tours are easier to do, video tours are shown to have higher success rates across the board.

Looking for more ways to attract and retain more patients? Check out DrMarketingTips.com for free articles, webinars, ebooks, audio blogs and more for your practice.

Jennifer Thompson is co-founder and chief strategist for DrMarketingTips.com, a website designed to help medical marketing professionals market their practice easier, faster and better.
Managing Mental Illness

By Sajid Hafeez, MD

When it comes to trusted professions, medical professionals are typically at the top of the list. This trust is often based in a sense of powerlessness when someone is sick and seeking a return to health from someone with more knowledge. All too often, the patients see a doctor as a miracle worker who knows exactly what the problem is and how to treat it. However, the modern health professional falls more closely to being a detective than anything else. Before the cure can be found, the whole story must be examined.

Many patients think that once the doctor finds the right pill, their mood will be fixed for good and all the problems go away. However, this is akin to putting a bandage over cancer. Sure, it makes a person feel better at first, but the real problem is still there festering under the surface, growing stronger. The goal of acute inpatient care is to divine the root cause of the problem that has put the patient into a crisis state. Only after this cause is discovered, can it be dealt with and successfully managed.

Managing mental illness is not a one-stop-shop, but a lifelong process. Just like any plot from a mystery novel, the story of a person’s mental state has numerous twists, turns, secrets, and factors that must be uncovered. It is the job of a psychiatrist to be a detective of the mind if the story is to have a happy ending. But just as a detective could never solve a case on his own, so too does the doctor employ the help of informants in the form of nurses, technicians, and therapists.

So how then does this investigative team discover the root problem? It’s nothing as exciting as going under cover or spying. In truth, most patients will eagerly volunteer the information when they feel they are being asked by someone who genuinely cares about their well being. A simple willingness to listen without judging will produce the most significant information. “So how is it that you ended up here?” “What is troubling you in your life?” “If you could change aspects of your life, what would you change?” “How can we help you?” When given a chance, patients will often tell their story because they want to be understood. These simple interrogation techniques will reveal the underlying issues that are concurrent with biological factors of the body that may predispose someone toward a mental illness.

While medications may allow for more neurotransmitters to be available in the brain’s chemistry, medications do not help a
patient handle the death of a brother. Medications do not pay off the bills that threaten to put a person onto the street. Medications do not help someone stand up to a bully. Because of this, a doctor understands that medication is but one part of the overall picture.

Throughout the stay, these situational causes and environmental clues as to the root of the problem are slowly uncovered. Each day, the doctor gathers his team to form an investigational brain-trust to discuss the patient unique problems and come up with a plan of action to treat them. The nurses may volunteer information on how the patient has been responding to medications. The therapists may reveal the patient’s secrets that were finally elicited from a successful session. The case managers may provide information from secondary sources such as guardians or spouses. The technicians may report the patient’s interactions with others and how they present on the unit. Each of these points of view provides the doctor with invaluable information that creates a narrative of the patient’s life. As the team better understands the bigger-picture, it is then possible to construct a plan of action, and custom fit it to the patients needs to guide him or her to stability.

Some patients may benefit from medication. Some patients may only need therapy. Other patients may need a plan to rescue them from an external situation in life. Often times, patients may need all of the above. Some issues may be caused from organic or disease causes. Yet the fact that remains true throughout is that the more information that doctor is privy to through the investigation of his team, the greater the chance of success in treatment. It is only when the detective in a novel has put together the whole story is he able to crack the case and discover who or what is the real guilty party. So too does the doctor crack the case of the cause of the illness. And while there may be no such thing as a magic bullet, the treatment team provides the patient with enough bullets opportunity to increase the patient’s chances of hitting the mark of stability.

Sajid Hafeez, M.D., is a child and adolescent psychiatrist who is serving as a Medical Director of the Acute Care Baker Act Unit at the University Behavioral Center. He also served as the Center’s Medical Director of the long term Residential Units: ASAPP Unit (for adolescent boys with inappropriate sexual behaviors), Solutions Unit (for adolescent boys with behavior problems), Promises and Stars Unit (for adolescent females with behavioral problems as well as victims of sexual abuse), and Discovery Unit (for children ages 5-13 with behavioral as well as inappropriate sexual problems). In addition, Dr. Hafeez also served as an Assistant Professor of Psychiatry at the University of Central Florida (Voluntary Position). He was also the Chief of the Adolescent Psychiatry Unit, an Attending Psychiatrist of the Comprehensive Psychiatry Emergency Program and of the Mobile Crisis Team at the Westchester Medical College. At Vassar Brothers’ Medical Center in New York. Dr. Hafeez was the Director of Outpatient Child & Adolescent and Adult Psychiatric Clinic as well as Director of Consultation and Liaison Psychiatry.

Dr. Hafeez received his adult Psychiatry and Residency Training at the University of Kansas Medical Center in Kansas City. He received his Child and Adolescent Psychiatry fellowship training at the New York Medical College New York and at Children’s National Medical Center of George Washington University in Washington, DC. Dr. Hafeez can be reached at 407-281-7000 or by visiting www.universitybehavioral.com.
Morton’s Neuroma Treatment Allows Patients to Walk Without Pain Again

By Corey Gehrold

Think about how many steps you take during any given day. Now imagine if every time your foot landed it felt like you were stepping on a sharp pebble.

If you experience prolonged foot pain like this, you may be suffering from a condition called Morton's neuroma.

“Morton’s neuroma is a painful nerve condition that affects the ball of the foot most commonly between the third and fourth toe,” says Daniel L. Wiernik, D.P.M., a podiatrist at Orlando Orthopaedic Center who is board certified in foot surgery and reconstructive rearfoot/ankle surgery. “The nerve becomes inflamed and when left untreated, the pain can become very severe.”

The pain caused from Morton’s neuroma can make it difficult to wear shoes or walk at all for any extended amount of time. When conservative non-surgical treatments fail, the affected neuroma may be removed through a minimally invasive surgery.

Kathleen, a recent patient of Dr. Wiernik’s, had two Morton’s neuromas removed during her recent surgery. She dealt with the pain for three years before deciding to have the surgery; but, now that she is fully recovered from her procedure, she says she feels great and her only regret is waiting so long to have the neuromas removed.

“I feel wonderful. The biggest benefit is not have excruciating pain and sharp pain in the ball of my foot,” says Kathleen. “Dr. Wiernik said most patients he had came back and said ‘I wish I had done it sooner.’ And he was right, I wish I had done it sooner.”

CAUSES AND SYMPTOMS OF MORTON’S NEUROMA

Morton’s neuroma is typically caused by irritation, pressure or injury to one of the nerves that lead to the toes. Wearing high heels, certain sports like running and tennis, and foot deformities can lead to a higher risk of Morton’s neuroma.

Symptoms of Morton’s neuroma include:

- Pain on weight-bearing
- Feeling as if you’re standing on a pebble in your shoe
- A burning pain in the ball of your foot that may radiate into your toes
- Numbness, tingling or paraesthesia in your toes

“My son got married in November and I couldn’t even wear shoes. I wore a dressy sandal and got by,” says Kathleen. “But even dancing in the low sandal - it had a low heel - it was just excruciating by the end of the night.”

Kathleen says she was in constant pain and it was lessening her quality of life on a daily basis.

TREATMENT OPTIONS FOR MORTON’S NEUROMA

Depending on how severe the pain is will determine which treatment option is best for someone suffering from Morton’s neuroma. Customized shoes, orthotic arch supports, foot pads or steroid injections may help ease the pain enough for some individuals to forgo surgery. However, if non-surgical treatments fail, surgery is considered the best option to treat the discomfort.

“During surgery, I remove the neuroma,” says Dr. Wiernik. “This removes the damaged nerve tissue from the foot and will give patients a reduction in discomfort. Unfortunately, the surgery will likely result in the permanent loss of feeling in the affected area.”

Removing a Morton’s neuroma is an outpatient surgery performed with anesthesia, meaning patients will return home later the same day without any extended hospital stays.

“The day of surgery was great,” says Kathleen who did a lot of research before choosing Dr. Wiernik as her surgeon. “The staff was very nice, caring and personable; and they took me in right on time and explained everything to me. I couldn’t have asked for better care.”

RECOVERY EXPECTATIONS WITH MORTON’S NEUROMA SURGERY

Recovery from surgery will typically take about six-eight weeks. At first, need to limit some weight on their foot, but in time they will be able to walk normally.

“In three weeks’ time I was walking with a shoe,” says Kathleen. “In five weeks I went to EPCOT and walked for 14 hours in the shoes I couldn’t wear [before my surgery].”

Kathleen says having surgery with Dr. Wiernik allowed her to be back on her feet without pain; and it’s one of the best things she has ever done.

“I’m doing great - I’m walking,” Kathleen says with a smile. “I haven’t started wearing heels or that type of shoe yet, but certainly I can wear my tennis shoes or sandals and be comfortable.”

Watch Kathleen’s full story at OrlandoOrtho.com.
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It’s been more than 100 years since doctors in Germany performed the first known breast augmentation.

In that time, cosmetic surgery has become a popular elective procedure among many demographics, with everyone from teenagers to people 55 and older undergoing surgical and minimally-invasive procedures.

Last year, more than 1.67 million people had cosmetic surgery. Breast augmentation remained the most popular cosmetic procedure last year, followed by nose reshaping, liposuction, eyelid surgery and facelifts, according to the American Society of Plastic Surgeons.

But minimally-invasive treatments are becoming increasingly popular. Non-surgical fat reduction procedures rose 43 percent last year, and Botox, fillers, chemical peels and laser hair removal rose 3 to 7 percent, according to the American Society for Aesthetic Plastic Surgery. In 2014, nearly 14 million people opted for non-invasive treatments, accounting for the majority of cosmetic procedures in the U.S. last year.

As a plastic surgeon, I see more patients opt for minimally-invasive procedures because they want treatments that enhance their appearance without the long recovery time or potential post-surgical complications.

Though plastic surgeons are in the business of making people feel and look their best, invasive surgery isn’t right for everyone, even though often it produces great results. There’s an emerging school of thought in our industry that believes prevention at an early age, in combination with non-invasive therapies, can help patients maintain a natural appearance without the need for an invasive procedure in the future.

Minimally-invasive therapies like laser treatments, Ultherapy, CoolSculpting, microneedling and radio frequency treatments like ThermiRF™ are growing in popularity. Here’s what you need to know about these procedures.

**LASER TREATMENTS**

More than 543,000 people underwent laser skin resurfacing treatments last year. Fraxel laser treatments, which use a fractional laser to smooth the skin and minimize spots and discoloration, have been the standard. However, many patients are concerned about the level of pain associated with this treatment, even after a doctor applies numbing cream to minimize the pain.

But new technologies have emerged to solve this problem. Mixto laser treatment is just one example. During this procedure, we use a micro-fractional CO2 laser to achieve better results with less pain and a shorter recovery period. Another benefit of Mixto is that a single treatment can achieve a better outcome than multiple treatments with a fractional laser, lowering the costs for patients and the time they spend in the doctor’s office.

**ULTHERAPY**

People who want improvement in the appearance of sagging skin on their face, back and chest but aren’t ready for a surgical procedure can now opt for Ultherapy—the only non-invasive treatment that is FDA-approved for this purpose.

Ultherapy uses targeted ultrasound to stimulate collagen in the deeper layers of the skin, tightening the skin in almost the same way a facelift does. However, Ultherapy naturally activates the tissues to produce more collagen over a two to three month period, and the results improve over time.

The major benefit of this treatment is that it only takes an hour and a half. Compared to surgery, it also doesn’t require weeks of downtime. Ultherapy is a relatively new procedure, so we don’t yet have comprehensive data on the number of people who have elected this treatment. However, I’m sure Ultherapy will become more popular as more people discover its benefits. It’s a great preventative measure for people who have begun to see signs of aging but don’t need a facelift or an intensive surgical procedure to improve their skin.

**COOLSCULPTING**

CoolSculpting has been around for several years, but also is gaining popularity among those who want results and convenience when improving their appearance.

During CoolSculpting, we use a suction cup with cooling plates to freeze the body’s fat cells. The fat cells then crystallize and die within the body, which reabsorbs and sheds them over the next few weeks. Between 20 to 25 percent of the fat cells within the targeted areas are destroyed during each treatment.

CoolSculpting is FDA-approved and the procedure only lasts an hour. It doesn’t require anesthesia or a long recovery time. Most patients say there is minimal or no pain with the procedure—they feel some tugging from the suction and a few minutes of coldness before the skin becomes numb.

Though many people get great results with this procedure, it’s important to understand that the outcome won’t be the same as liposuction. For people who want more significant fat reduction, liposuction is still the best option.

**MICRONEEDLING AND THERMIRF™**

Versatility often is very important when it comes to cosmetic procedures. Some treatments only focus on specific areas, but procedures that improve multiple areas of the body are very attractive options for patients.

Microneedling fits into this category. Also called collagen induction therapy, microneedling is a new non-invasive skin rejuvenation procedure in which we use needles to create very small punctures in the skin. These micro injuries trigger the production of new collagen and elastin, which improves the skin’s appearance without scar formation.

SkinPen is one of the most popular microneedling devices cur-
rently on the market. This 30-minute procedure improves the appearance of acne scars, discoloration, fines lines, stretch marks, wrinkles and other skin issues caused by sun damage and aging. One of the most attractive things about SkinPen is its versatility. It can be used on every part of the body, including the abdomen, arms, back, decolletage, face, hand, legs and neck. Recovery time is minimal and some patients may experience some redness for 24-48 hours after the procedure.

ThermiRF™ is another treatment with multiple applications. This non-surgical, minimally invasive procedure is a great alternative to skin tightening. After a small amount of anesthetic is injected, ThermiRF™ uses a temperature controlled radio frequency device, which is inserted through tiny probes under the skin, to stimulate collagen. It is FDA-approved to treat a variety of areas, including the brow, neck, arms and legs, and also as a skin smoothing treatment and for vaginal rejuvenation. Patients only need one ThermiRF™ treatment, and downtime is minimal—patients can resume their normal activities the day after their treatment.

Minimally-invasive procedures will continue to gain popularity. A recent Wall Street Journal article contended that “in 10 or 20 years, [minimally-invasive therapies] might make some surgery obsolete.” That may be true in some respects, especially when these treatments are used appropriately as preventative steps in a skincare regimen.

Until then, some procedures still may be surgically necessary. If you are considering any of these treatments, research your doctor beforehand and make sure he or she is a board-certified plastic surgeon. These treatments may be minimally-invasive, but they still are considered medical procedures. Only a qualified professional should perform them.

Armando Soto, MD, FACS is a board-certified plastic surgeon with membership in the esteemed American Society of Plastic Surgeons, as well as the American Society for Aesthetic Plastic Surgery, an organization comprised of strictly aesthetic surgeons who are also certified by The American Board of Plastic Surgery. Dr. Soto is also a Fellow in The American College of Surgeons, an organization dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment. Dr. Soto earned his medical degree at the world renowned John’s Hopkins School of Medicine, in Baltimore, MD, and received training in general and plastic surgery in the prestigious program of The Barnes-Jewish Hospital of Washington University, St. Louis (the birthplace of American Plastic Surgery). For more on Dr. Soto, please visit www.drarmandosoto.com.
Doc Fix Bill Helps Doctors Dodge Bullet, But More Bullets on the Way

By Marni Jameson

When President Obama signed the Doc Fix bill on April 16, independent doctors nationwide exhaled in collective relief. They'd dodged a bullet.

The threatened 21 percent Medicare cuts to doctors, a byproduct of the ill-conceived Sustainable Growth Rate formula, had at last ended. For eighteen years the SGR-governed cuts had been accruing and hanging like the sword of Damocles over independent doctors' heads. They were poised to go into effect April 1.

But the Doc Fix bill, which enjoyed overwhelming bipartisan support, with the house voting 392 to 37 in favor of the legislation, and the senate voting 92 to 8, put an end to that threat. And replaced it with another.

Thus, the new law is a Pyrrhic victory. But let's celebrate the victory nonetheless. Had SGRs not been repealed, many independent doctors would have faced a difficult choice, and many Medicare patients would have been without access to care. If the cuts had gone into effect, doctors would have had to choose from the following options:

• Go to work for the hospital, (i.e., sell out).
• Go into concierge medicine.
• Opt out of Medicare.
• Take a 75 percent pay cut.

Seventy-five percent!? How does a 21 percent cut in Medicare become a 75 percent pay cut?

This is what few lawmakers and even fewer consumers realize.

Let's go through the math: Say an independent doctor who treats primarily Medicare patients brings in $35,000 a month in Medicare reimbursements. His overhead is $25,000 a month. That makes his monthly net profit $10,000. An annual income of $120,000 a year is by no means a killing for a primary care doctor.

Now, let's say Medicare reimbursements dropped by 21 percent, so instead of getting $35,000 a month, the doctor gets $27,650. However, overhead – rent, salaries, utilities, insurance, supplies -- doesn't change. If anything it goes up. Thus, that 21 percent (or $7,350) cut, comes straight out of the doctor's net profit, which drops from $10,000 a month to $2,650, almost 75 percent less for the same work.

Instead of earning $120,000 a year, the doctor's income would drop to $31,800 -- less than their office managers.

Fortunately, that didn't happen. But we came too close.

We came dangerously close to a perilous outcome for doctors, patients and America's health care system for two reasons:

• The misguided notion that doctors' fees are the problem.
• The dreadfully poor representation of independent doctors in government.

Doctors are not why health-care costs too much in this country. In fact, physician fees account for only eight cents out of every health-care dollar spent. Far larger shares go to hospitals, ancillary services and pharmaceuticals.

But independent doctors are easy targets, and somewhere along the line, they found themselves in the crosshairs. This is largely because -- until recently -- they have been notoriously bad at coordinating their efforts, defending themselves and lobbying effectively.

Some believe it's the American Medical Association's job to lobby for them. But, of course, the dwindling membership of the AMA comprises mostly employed physicians and academics. The only national organization dedicated exclusively to the rights of independent doctors is the Association of Independent Doctors (www.aid-us.org), a two-year-old nonprofit who has begun to take up the fight to give these doctors a voice.

Part of that fight will include helping doctors dodge the bullets loaded in the Doc Fix bill. Just as they exhale with relief from cuts that would have made maintaining their private practices unsustainable, they now had better brace themselves for what else was buried in that bill.

Under the new law, doctors who see Medicare patients will get a modest pay increase, but those payments will be tied to how well doctors comply with government mandates. Whether doctors get rewarded or penalized for their performance will depend on how well they comply and coordinate care. As one analyst anticipates, “Expect heavy lobbying from the physician community on every element of implementation.”

When Obama signed the Doc Fix bill into law, doctors got a short-lived reprieve. They got themselves out of the frying pan all right. Now they will need to get out of the fire.

Marni Jameson is the executive director for the Association of Independent Doctors. You may reach her at 407-865-4110 or marni@aid-us.org.

Be sure and check out our website at www.floridamd.com!
Pelvic Floor Dysfunction-Part 1

By Sergio Larach, MD

Note: This article is written in two parts. Part one will cover Pelvic Floor Dysfunction: Definition, Diagnosis, and Treatment. Part two will be published in the next edition and will cover Bowel Incontinence: Definition, Cause, and Treatment Options.

Many people don’t feel comfortable talking about personal topics like pelvic floor disorders and symptoms such as incontinence. But these are actually very common medical problems that can be treated successfully. Millions of people have the same issues, but many don’t seek treatment and compromise their quality of life. Treatment can have a dramatic effect on pelvic floor dysfunction.

Pelvic floor dysfunction refers to a wide range of issues that occur when muscles of the pelvic floor are weak, tight, or there is an impairment of the sacroiliac joint, lower back, coccyx, or hip joints. Tissues surrounding the pelvic organs may have increased or decreased sensitivity or irritation resulting in pelvic pain. Many times, the underlying cause of pelvic pain is difficult to determine.

Pelvic floor dysfunction may include any of a group of clinical conditions that includes urinary incontinence, fecal incontinence, pelvic organ prolapse, sensory and emptying abnormalities of the lower urinary tract, defecatory dysfunction, sexual dysfunction and several chronic pain syndromes, including vulvodynia. The three most common and definable conditions encountered clinically are urinary incontinence, anal incontinence and pelvic organ prolapse.

It is estimated that at least one-third of adult women are affected by at least one of these conditions. Furthermore, statistics show that 30 to 40 percent of women suffer from some degree of incontinence in their lifetime, and that almost 10 percent of women will undergo surgery for urinary incontinence or pelvic organ prolapse. 30 percent of those undergoing surgery will have at least two surgeries in trying to correct the problem.

WHAT IS PELVIC FLOOR DYSFUNCTION?

For most people, having a bowel movement is a seemingly automatic function. For some individuals, the process of evacuating stool may be difficult. Symptoms of pelvic floor dysfunction include constipation and the sensation of incomplete emptying of the rectum when having a bowel movement. Incomplete emptying may result in the individual feeling the need to attempt a bowel movement several times within a short period of time. Some times use of digital help during the evacuation for support of the pelvic floor. Residual stool left in the rectum may slowly seep out of the rectum leading to reports of bowel incontinence. Constipation is not about frequency (or infrequency) of bowel movements, but rather chronic constipation is a “symptom complex.”

The process of defecation (having a bowel movement) requires the coordinated effort of different muscles. The pelvic floor is made up of several muscles that support the rectum like a hammock. When an individual wants to have a bowel movement the pelvic floor muscles are supposed to relax allowing the rectum to empty. While the pelvic floor muscles are relaxing, muscles of the abdomen contract to help push the stool out of the rectum. Individuals with pelvic floor dysfunction have a tendency to contract instead of relax the pelvic floor muscles. When this happens during an attempted bowel movement, these individuals are effectively pushing against an unyielding muscular wall.

Chronic constipation may be associated with normal or slow stool transit time, functional defecation disorder (dyssynergic defecation) or a combination of both. With slow-transit constipation, there is a prolonged delay in the transit of stool through the colon. Dyssynergic or outlet obstruction (also called pelvic floor dyssynergia) is characterized by either difficulty or inability to expel the stool. With pelvic floor dysfunction (dyssynergic defecation), the muscles of the lower pelvis that surround the rectum (the pelvic floor muscles) do not work normally. A third type of constipation occurs with irritable bowel syndrome (IBS) where constipation alternates with bouts of diarrhea.

HOW IS PELVIC FLOOR DYSFUNCTION DIAGNOSED?

The diagnosis of pelvic floor disorder starts with a careful history regarding an individual’s symptoms, medical problems and a history of physical or emotional trauma that may be contributing to their problem. Next the physician examines the patient to identify any physical abnormality. A dynamic MRI and a defecating proctogram are studies commonly used to demonstrate the functional problem in a person with pelvic floor dysfunction. During this study, the patient is given an enema of a thick liquid that can be detected with x-ray. A special x-ray video records the movement of the pelvic floor muscles and the rectum while the individual attempts to empty the liquid from the rectum. Normally the pelvic floor relaxes allowing the rectum to straighten and the liquid to pass out of the rectum. This study will demonstrate if the pelvic floor muscles are not relaxing appropriately and preventing passage of the liquid.

These tests are also useful to show if the rectum is folding in on itself (internal rectal prolapse). Many women have outpouching of the rectum known as a rectocele. A rectocele is a bulging of the front wall of the rectum into the back wall of the vagina. Rectoceles are usually due to thinning of the rectovaginal septum (the tissue between the rectum and vagina) and weakening of the pelvic floor muscles. This is a very common defect; however, most women do not have symptoms. There can also be other pelvic organs that bulge into the vagina, leading to similar symptoms as rectocele, including the bladder (i.e., cystocele) and the small intestines (i.e. enterocele).

continued on page 24
Usually a rectocele does not affect the passage of stool. In some instances, however, stool may become trapped in a rectocele causing symptoms of incomplete evacuation. The defecating proctogram or dynamic MRI helps to identify if liquid is getting trapped in a rectocele when the individual is trying to empty the rectum.

**HOW IS PELVIC FLOOR DYSFUNCTION TREATED?**

Pelvic floor dysfunction due to non-relaxation of the pelvic floor muscles may be treated with specialized physical therapy known as biofeedback. With biofeedback, a therapist helps to improve a person's rectal sensation and pelvic floor muscle coordination. There are various effective techniques used in biofeedback. Some therapists train patients by teaching them to expel a small balloon placed in the rectum. Another technique uses a small probe placed in the rectum or vagina or electrodes placed on the surface of the skin around the opening to the rectum (anus) and on the abdominal wall. These instruments detect when a muscle is contracting or relaxing and provide visual feedback of the muscle action. This visual feedback helps the individual to understand the muscle movement and aids in improving muscle coordination. Approximately 75% of individuals with pelvic floor dysfunction experience significant improvement with biofeedback.

It is very important to have a good bowel regimen in order to avoid constipation and straining with bowel movements. A high fiber diet, consisting of 25-30 grams of fiber daily, will help with this goal. This may be achieved with a fiber supplement, high fiber cereal, or high fiber bars. In addition to augmenting fiber intake, increased water intake (typically 6-8 glasses daily) is also highly recommended. This will allow for softer stools that do not require significant straining with bowel movements, thereby reducing your risk for having a bulge associated with a rectocele. The surgical management of rectoceles should only be considered when symptoms continue despite the use of medical management and are significant enough that they interfere with activities of daily living. There are abdominal, rectal, and vaginal surgeries that can be performed for rectoceles.

Rectal prolapse is a condition in which the rectum (the lower end of the colon, located just above the anus) becomes stretched out and protrudes out of the anus. Weakness of the anal sphincter muscle is often associated with rectal prolapse at this stage, resulting in leakage of stool or mucus. While the condition occurs in both sexes, it is much more common in women than men. There are many different ways to surgically correct rectal prolapse.

Abdominal or rectal surgery may be suggested. An abdominal repair may be approached laparoscopically in selected patients. The decision to recommend an abdominal or rectal surgery takes into account many factors, including age, physical condition, extent of prolapse and the results of various tests.

Part 2 of this article will discuss bowel incontinence in the next edition.

If a patient has pelvic health issue, don’t hesitate to learn more about treatment options, seek out an expert evaluation, at our center, we have state-of-the-art technology for physiologic testing and a multidisciplinary approach to patients with complex pelvic floor disorder.

**REFERENCES**

Jennifer Speranza, MD, FACS, FASCRS, on behalf of the ASCRS Public Relations Committee © 2012 American Society of Colon & Rectal Surgery

National Institute of Child Health and Human Development (NICHD) a unit of the National Institutes of Health (NIH).

Sergio Larach, MD completed his fellowship at the University of Texas Medical School. He is board certified in colon and rectal surgery. His interests include the whole spectrum of colorectal issues, and his addition to our practice will involve colonoscopies, anorectal diseases and pelvic floor evaluations. Dr. Larach is fluent in Spanish.

He has held multiple professional appointments through his career, including Program Director of Orlando Health’s and Florida Hospital’s Colon and Rectal Fellowship Programs. Dr. Larach is currently a Clinical Associate Professor at University of Central Florida and Clinical Associate Professor at Florida State University.

Dr. Larach has also published numerous articles on colon and rectal surgery, conducted clinical research, and authored book chapters in his specialty. He has been instrumental in the development of the TAMIS procedure for the treatment of rectal cancers.

He is the Associate Director of International Advisory Affairs of the International Society of University Colon and Rectal Surgeons and is also a reviewer for the Surgical Endoscopy journal.

To contact Dr. Sergio W. Larach, please call Digestive and Liver Center of Florida at 407-384-7388.

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HPV Testing Alone for Cervical Cancer Screening  
By Lori Boardman, MD

The past decade has witnessed a series of significant changes to the way in which women are screened for cervical cancer and reflect accumulating evidence from clinical trials and cohort studies as to the natural history of human papillomavirus (HPV) infection and its role in the development of cervical cancer and its precursors. That persistent infection with high-risk types of HPV (hrHPV) is necessary for the development of cervical cancer is well recognized. Although hrHPV infection is common, particularly in younger women, it is often transient and clears without clinical repercussions. Persistent infection, however, places women at risk for the development of cervical neoplasia and cancer. The addition of HPV testing to cervical cancer screening recommendations began with the publication of the 2001 Consensus Guidelines for the Management of Women with Cervical Cytopathological Abnormalities. Based on data from the NCI-initiated ASCUS-LSIL Triage Study (ALTS), reflex HPV DNA testing was recommended as one option for the management of women with ASC-US.1

While high-risk HPV testing has been endorsed in a number of other clinical settings (e.g., for surveillance following treatment for cervical neoplasia), hrHPV testing was not incorporated as an adjunct to cervical cytology in primary screening regimens in the U.S. until 2006.2 Currently, numerous organizations including ACOG, the American Cancer Society, and the United States Preventive Services Task Force recommend screening for cervical cancer in low-risk women age 30 to 65 years with either cytology alone every 3 years or a combination of cytology and hrHPV testing (cotesting) every 5 years. In the setting of cotesting, two options for management of hrHPV-positive, cytology-negative women are recommended: repeat cotesting in 12 months or immediate HPV genotype-specific testing for HPV 16 and 18.3 5

Although hrHPV testing alone-based screening had appeared promising at the time of publication of the above guidelines, recommendations for its use were not made due to the lack of well-defined management strategies for positive tests, the potential for significant harms from unnecessary procedures or treatment, as well as a concern for potential false negative tests due to lack of internal controls for specimen adequacy among some HPV assays.3 In the interim, a number of large studies have been published, including new primary screening data as well as updates on subsequent rounds of screening from ongoing trials. What was consistently demonstrated in the majority of studies was an improved sensitivity of primary hrHPV screening for detecting high-grade cervical lesions (CIN2 and CIN3) and cancer compared to screening with cytology alone. For example, Ronco analyzed data from four major European trials in which hrHPV screening was compared to cytology. Although the detection of invasive cancers was similar between the two screening methods during the first 2.5 years of follow-up, fewer cancers were subsequently detected in women undergoing HPV screening. These findings led the investigators to conclude that HPV-based screening protected 60–70% more women from invasive cervical cancer than did cytology-based regimens.6

Based on the accumulating data, both the Netherlands (2013) and Australia (2014) announced changes to their national cervical cancer screening programs, endorsing replacement of current cytology-based screening with HPV testing. On March 12, 2014, the United States Food and Drug Administration (FDA) approved modified labeling of a currently marketed hrHPV assay to include primary hrHPV screening for women 25 years and older. The data supporting this application came from a large, prospective trial of primary hrHPV screening called ATHENA (Addressing the Need for Advanced HPV Diagnostics). In 3-year end-of-study results from this trial, primary HPV testing had the highest adjusted sensitivity for CIN3+ (76.1%; 95%CI: 70.3-81.8%). In comparison, the adjusted sensitivities of cotesting or cytology were 61.7% (95%CI: 56.0-67.5%) and 47.8% (95%CI: 41.6-54.1%), respectively. While primary HPV screening led to detection of more cases of high-grade disease, it required significantly more colposcopies compared to cytology or cotesting. Lastly, and relevant to the FDA decision to approve an HPV test to be used

<table>
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Table 1: CIN3+ and cancer risks 3 and 5 years after negative hrHPV, cotesting and cytology. (adapted from Huh, 2015)
in primary screening of women aged 25-29, was data from ATHENA demonstrating that women in this age group, while only 16% of the study population, represented 34.3% of the cases of CIN3+. More than half of the women aged 25-29 with CIN3+ had negative cytology. 

Interim clinical guidance, triggered by the FDA application, was published in early 2015 to provide information to those interested in primary hrHPV testing, its advantages and disadvantages, and to highlight areas of further investigation. Key findings include the following:

- A negative hrHPV test confers greater reassurance of low CIN3+ risk than a negative Pap test. As seen in Table 1, primary hrHPV screening with a negative result with a 3-year screening interval is at least as effective as five-year cotesting.

- Re-screening after a negative hrHPV test should occur no sooner than every 3 years. Although a longer screening interval is safer than cytology every three years, most of the studies included below used 3-year screening intervals, and the prospective U.S. trial (ATHENA) provided only 3-year follow-up data.

- Based on limited data, triage of hrHPV-positive women using a combination of HPV 16 and 18 genotyping and reflex cytology for women who are positive for the 12 other hrHPV genotypes is reasonable. From a number of studies, the 3-year cumulative incidence of CIN3+ for HPV 16/18-positive women ranges from 21-26% compared to 5.4-6.6% for women who test positive for hrHPV genotypes other than 16 and 18. Modeling studies, based on the ATHENA trial, compared various triage strategies and found the algorithm below achieved a balance between safety and test utilization, missing few cases of CIN3+ and requiring reasonable numbers of screening tests and colposcopies.

- Primary hrHPV screening should not be initiated in women < 25 years of age. One of the major concerns of beginning screening at age 25 has been the number of colposcopies required, despite the increased detection of disease. The majority of disease detected in 25-29 year olds will be CIN3; whether identifying CIN3 at this age translates into a meaningful reduction in cancer remains unclear.

- False negative results will continue to occur.

While the use of hrHPV testing as a primary screening test is not currently incorporated into any major screening guideline recommendations in the U.S., it is to be expected that updated triage recommendations will likely follow. Concerns, however, remain. Provider compliance with existing guidelines is poor, and introducing yet another alternative to current screening recommendations will likely increase confusion for providers and patients. How the new test will compare to cotesting needs further clarification. Over-use of testing and treatment is common, harms of screening are underappreciated, resource utilization has not been adequately addressed, and understanding women’s preferences for screening are all needed in order to move cervical cancer screening forward in a thoughtful and purposeful manner.

Lastly, the majority of cervical cancers in the U.S. occur in unscreened or underscreened women. Determining ways to better address screening in these populations remains critical, as does HPV vaccination uptake, which is similarly underused in the U.S.

References available upon request.

Lori Boardman, MD, ScM, is the Executive Medical Director of the Florida Hospital for Women and Professor of Obstetrics and Gynecology at the University of Central Florida College of Medicine. She was a member of the consensus panels for the ASCCP 2006 Consensus Conference on the Management of Women with Cytologic and Histologic Abnormalities and the ASCCP 2012 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer Precursors. She also served as Vice Chair of the ACOG Practice Bulletin-Gynecology Committee and oversaw the development of the 2012 ACOG Practice Bulletin on screening for cervical cancer. To learn more visit FH4Women.com or call 407-303-4HER.

COMING UP NEXT MONTH:
The cover story focuses on University Behavioral Center. Editorial focus is on Allergies and Sleep Disorders.
Cardio-oncology is a new discipline that is gaining increasing importance in the clinical fields of cardiology and oncology. It is a program with strong collaboration between cardiologists and oncologists (both clinical and radiation). The goal of the program is to improve outcomes of oncology patients receiving cardiotoxic chemotherapy and radiation therapy.

EPIDEMIOLOGY
Cancer and cardiovascular disease are common in aging populations, and hence it is not uncommon to encounter patients with cancer and cardiovascular disease. Although the cardiotoxicity from certain chemotherapeutic agents and radiation therapy can happen in any age group, pre-existing cardiovascular disease and age increase the incidence of such toxicity.

Cancer survivorship is becoming increasingly common with the advent of newer chemotherapeutic agents. Many cardiologists are now treating cancer survivors. Cardiologists, like their oncology colleagues, have to be familiar with the ever-increasing list of chemotherapeutic agents and their potential toxicity. Several of these agents are associated with short-term as well as long-term toxicity.

CARDIOTOXICITY
Cardiotoxicity can be acute (from initiation of therapy up to two weeks after termination of treatment) or chronic (early toxicity that occurs within one year and late toxicity that occurs after one year). Acute cardiotoxicity can manifest as QT interval changes, hypertension, acute heart failure syndromes, arrhythmias (ventricular and supraventricular), acute coronary syndromes, thromboembolism, myocarditis and pericarditis-like syndromes. Chronic cardiotoxicity can manifest as cardiomyopathy, heart failure, accelerated atherosclerosis, conduction system disease, valvular heart disease and pericardial disease. The following are examples of cardiotoxicity and the chemotherapeutic agents causing them:

• Left ventricular dysfunction: Anthracyclines (daunorubicin, doxorubicin, etc.), alkylating agents (cyclophosphamide), tyrosine kinase inhibitors (both monoclonal antibody based and small molecule)
• Myocardial ischemia: Tyrosine kinase inhibitors and fluorouracil
• Hypertension: Tyrosine kinase inhibitors
• Venous thromboembolism: Tyrosine kinase inhibitors and alkylating agents (cisplatin)

RADIATION THERAPY
Acute toxicity from radiation therapy is rare and can cause acute pericarditis and myocarditis. Long-term toxicity can manifest as myocardial damage, valvular heart disease, coronary artery disease, pericardial disease, conduction system disease, etc.

The toxicity is dependent, among other factors, on the cumulative dose received and the individual’s age at radiation exposure, with younger patients having the greatest risk. The estimated aggregate incidence of radiation-induced heart disease is 10-30 percent by 5-10 years post-treatment and increases with time.

PATHOPHYSIOLOGY
Various mechanisms for cardiotoxicity have been put forth. Cell death has been implicated due to increased oxidative stress and free radical formation. A classic example for this type of toxicity is anthracycline-induced cardiotoxicity. Cardiotoxicity from some of the tyrosine kinase inhibitors has been reported as suppression of cardiomyocyte human epidermal growth factor II. Some other agents have been known to cause ATP depletion. In some other agents it is due to reasons of unclear origin. Inflammation and
tissue fibrosis has been postulated to be the pathophysiology behind radiation-induced heart disease.

**RISK ASSESSMENT**

Several factors need to be taken into consideration when assessing the risk of an individual patient. Patient factors such as age and pre-existing comorbidities (hypertension, cardiovascular disease, etc.) must be carefully reviewed. The chemotherapeutic agent or agents and their potential toxicity need to be assessed. Finally, any concomitant radiation therapy and previous exposure to chemotherapy and/or radiation therapy need to be established.

**MONITORING**

The frequency and intensity of monitoring depend on the risk assessment as discussed in the previous section. There are currently no guidelines to address this issue; however, there has been considerable interest in using some of the cardiac biomarkers in monitoring high-risk patients. There are several studies utilizing troponins and BNP for monitoring these patients. Approximately one-third of the patients receiving anthracyclines have elevated troponin levels during chemotherapy, representing the population at risk for potentially irreversible myocardial injury.

Troponin levels can determine at least three months in advance of the occurrence of a clinically significant dysfunction of the left ventricle. The early increase of the troponin concentrations also predicts the degree and severity of future left ventricular dysfunction. Some studies indicate, among patients with positive troponin values, persistence of the increase one month after the last chemotherapy administration could be related to an 85 percent probability of major cardiac events within the first year of follow-up. On the other hand, a persistently negative troponin test result can identify, with a predictive negative value of 99 percent, patients with the lowest cardiotoxicity risk who will most likely never encounter cardiac complications, at least within the first year after the end of chemotherapy.

Data is somewhat conflicting and not robust for BNP from various studies. Concentrations of BNP increased after treatment with chemotherapeutic agents causing cardiotoxicity. BNP levels can correlate with development of diastolic dysfunction. Persistent increase indicates future development of cardiac dysfunction. In clinical practice, the monitoring is usually a combination of cardiac markers and cardiovascular imaging.

**TREATMENT**

Prompt recognition is crucial in the treatment of cardiotoxicity from cancer therapy. Treatment depends on the type of toxicity encountered. Standard heart failure therapies are recommended for LV dysfunction and/or heart failure. ACE inhibitors are the class of medications with the most data, followed by beta-blockers. The timing of recognition and initiation of treatment is of high importance. Recovery of left ventricular systolic function is possible and highly dependent on early treatment. Delay in therapy may lead to irreversible damage.

**GUIDELINES**

Unfortunately, there are no guidelines to address the approach, monitoring or treatment of patients undergoing cardiotoxic chemotherapy. There are some position statements and single center approaches published in literature.

**OUR PROGRAM**

At Orlando Health, we have established a cardio-oncology program to improve outcomes from cancer therapy in our community. Our program is run in collaboration with cardiologists, oncologists (medical and radiation), pharmacy services and the cardiovascular imaging department. Our goal is appropriate risk assessment before therapy for cancer is initiated so that high-risk patients can be closely monitored and treated, if necessary, as they undergo their much-needed and lifesaving therapies for cancer. We aim to preserve our patients’ heart health without any delay or interruption of cancer therapy. We at Orlando Health recognize the importance of assessment of these patients with utmost urgency to prevent any delay in cancer care.

**CONCLUSION**

Cardiotoxicity from cancer treatment is a major problem. Risk stratification can be performed, although every patient treated is at risk. Early detection is crucial not only to prevent long-term cardiovascular morbidity and mortality but also to continue their...
much-required cancer treatment. This can be done with close collaboration between oncologists and cardiologists.

**Carolina Demori, MD** joined the Orlando Health Heart Institute in 2012. She is originally from Venezuela and earned her Medical Degree from Luis Razetti Medical School. She trained in cardiovascular medicine at Rush University Medical Center, in Chicago, Illinois and in heart failure and heart transplantation at The University of Florida at Shands in Gainesville, FL. Dr. Demori is one of four physicians apart of the Women’s Heart Center which delivers advanced and comprehensive cardiovascular care specifically tailored to meet the needs of women’s hearts. Dr. Demori also directs the Heart Failure Program at Orlando Health Heart Institute. This program is intended to assist heart failure patients using the utmost and novel therapies currently available which include Left Ventricular Assist Device. Dr. Demori is board certified in cardiovascular medicine, nuclear cardiology, adult echocardiography, cardiovascular computed tomography, and advanced heart failure and cardiac transplantation. Her specialties include cardiovascular disease in women, heart failure and cardiac transplantation, pulmonary hypertension, and noninvasive cardiac imaging.

Swathy Kolli, MD, is board certified in internal medicine, cardiovascular disease, CBNC (nuclear cardiology), CBCCT (cardiovascular computed tomography) and echocardiography. She is a fellow of American college of cardiology. She joined Orlando Heart Center in 2012 and practices at the Sand Lake office.

Dr. Kolli earned her medical degree from Rangaraya Medical School in India. She completed an internal medicine residency at Saint Louis University where she also served as chief resident. Following her work there, she went on to complete a cardiology fellowship at University of South Florida in Tampa. Additionally, she received training in advanced cardiovascular imaging from Harvard University (Brigham and Women’s Hospital). She served as chief cardiovascular imaging fellow at Brigham and Women’s Hospital. Dr. Kolli’s special areas of interest include general cardiology, cardiovascular imaging including cardiac CT, cardiac MRI, 3D-Echo, PET, cardio-oncology (monitoring and treatment of patient undergoing cancer therapy), women’s heart health and preventive cardiology.

Dr. Kolli and Dr. Demori are the co-directors of the Cardio-Oncology program at Orlando Health Heart Institute.

For more information, visit orlandohealth.com/heartinstitute.
Women and Cardiovascular Disease

By Linda E. Jaffe, MD

Cardiovascular disease (CVD) remains the #1 killer of women, surpassing all cancers combined. In many countries, including the United States, more women than men die every year of CVD, and overall outcomes for women with coronary disease are worse than for men. 292,188 women died of heart disease in 2009, which is 1 in every 4 female deaths; unfortunately the CDC fact sheet published in 2013 notes that only 54% of women recognize heart disease as their number one killer. In addition to it being the leading cause of death in women, 38% of women (vs 24% of men) die within one year of their first coronary event, reminding us of the need for aggressive risk modification and early disease detection in women. Nearly two thirds of women who die suddenly of coronary heart disease have no previous symptoms.

The primary risk factors for women, as for men, include hypertension, diabetes mellitus, dyslipidemia, smoking and family history of early coronary artery disease. The NCEP has recognized the postmenopausal state as a risk factor for CVD in women, assigning it the same weight as male sex for men. The incidence of hypertension approaches 80% for women above age 70. Diabetes is a much more potent risk factor for women than men, increasing the risk of CVD 3 to 7 fold (vs 2 to 3 fold in men). It negates the protective effect of gender and doubles the risk of a second MI in women. Dyslipidemia is a significant risk factor for both men and women, but in women, a low HDL is more predictive than an elevated LDL for CVD and elevated triglycerides appear to be a more potent risk factor. Although attempts to increase HDL with a variety of agents have failed to impact cardiovascular deaths, more recent trial have suggested promising results with newer agents.

Smoking has been associated with one-half of all coronary events in women and even minimal use increases coronary risk. Fortunately, risk returns to baseline after 2 to 3 years and thus smoking cessation remains critical in the management of cardiac risk in women. Family history remains a non-modifiable risk factor but increases the importance of aggressive management of other risk factors. More recently, chronic kidney disease and peripheral vascular disease have been cited as risk factors for CAD. Secondary risk factors include obesity, increasing weight within the “normal” range, as well as the metabolic syndrome (abdominal obesity, glucose intolerance, hypertension and elevated triglycerides with a low HDL). A sedentary lifestyle is also associated with increased cardiac risk.

In 2004, the AHA published evidence based guidelines for CVD prevention in women and these guidelines were updated in 2007. Assessment of level of risk was fundamental to subsequent recommendations for intervention, and based on the 10 year absolute risk of CVD, patients were divided into high (>20%), intermediate (10 to 20%) and low (<10%) risk groups. A Framingham risk calculator has been published and can be found online at http://hp2010.nhlbi.nih.gov/atpiii/calculator.asp?usertype=prof. The more updated guidelines assess risk more generally, based on clinical findings. The “high risk” group includes established CVD, known cerebrovascular disease, peripheral arterial disease, abdominal aortic aneurysm, end-stage or chronic renal disease, diabetes mellitus or a 10-year Framingham global risk of >20%. Patients considered “at risk” are those with one or more of the risk factors described above, evidence of subclinical vascular disease (eg coronary calcification), poor exercise capacity on treadmill testing and/or abnormal heart rate recovery after stress testing. The guidelines emphasize lifestyle interventions which include a low fat diet, addition of omega 3 fatty acids, particularly in women with high triglycerides, physical activity with a goal of 30 minutes a day, maintenance of appropriate weight, smoking cessation, cardiac rehabilitation following acute cardiac events and screening for depression. Additional recommendations include an ideal BP goal of <120/80, treatment of dyslipidemia, preferably with statins, to achieve an optimal LDL determined by risk category and subsequent intervention as needed to achieve an HDL > 50 and triglyceride levels less than 150. Diabetes should be treated to attain a HBA1c level < 7%. These recommendations should be viewed in light of more recent studies suggesting no benefit of supplemental omega 3 fatty acids on cardiovascular outcome and somewhat higher ranges of acceptable BP per the most recent JNC 8 report.

The issue of when to use aspirin has sparked some interest in recent years. Clearly, aspirin at a dose of 75 to 325 mg/d is recommended in all high risk women, including every diabetic. Patients who are truly intolerant to aspirin should be considered for clopidogrel therapy. The use of aspirin in low risk women has been controversial. As recently as 2004, aspirin was not considered appropriate therapy in low risk women although a beneficial effect on the risk of ischemic stroke had been demonstrated. More recently, the recommendation has been to use low dose aspirin (81 mg daily or 100 mg every other day) in all women with a 10 year Framingham risk score of 6 to 10%. Additionally, in women 65 years of age or older, aspirin therapy should be considered if blood pressure is controlled and benefit for ischemic stroke and MI prevention is likely to outweigh risk of GI bleeding and hemorrhagic stroke. In women under 65, aspirin appears beneficial for ischemic stroke prevention but not for MI prevention.

The consideration of hormone replacement therapy (HRT) has undergone much change. Although it known that LDL and triglyceride levels increase after menopause and HDL decreases concurrently, and we know that these changes correlate with
increased CV risk, HRT has not been shown to offset this risk. Whereas multiple studies have failed to show a net benefit on CV outcomes with HRT, more recent analyses have suggested that early treatment, in the perimenopausal years, may have modest benefit. Recent recommendations support limited use of HRT as needed for perimenopausal relief for the shortest time period and at the lowest dose possible, beginning soon after onset of symptoms. There remains no role for HRT as preventive therapy for CVD.

Linda Jaffe, MD, is board certified in internal Medicine, cardiovascular disease and nuclear cardiology. She joined Orlando Health Heart Institute in 2004 and practices at both the downtown and east Orlando offices. Dr. Jaffe earned her medical degree from University of North Carolina at Chapel Hill and completed her internal medicine internship and residency at Columbia Medical Center in New York. She continued her cardiovascular disease education through a fellowship at Long Island Jewish Hospital. From 1990 to 2004 Dr. Jaffe was a clinical professor of medicine at Columbia University in New York and was a teaching attending at the Allen Pavilion of New York Presbyterian Hospital where she was Director of the Cardiac Diagnostic Center until relocating to Orlando in 2004.

The Women’s Cardiovascular Program at Orlando Health Heart Institute is lead by Dr. Jaffe, Illena Antonetti, MD, Carolina Demori, MD, and Swathy Kolli, MD.

For more information, visit orlandobhealth.com/heartinstitute.

COMING UP NEXT MONTH: The cover story focuses on University Behavioral Center. Editorial focus is on Allergies and Sleep Disorders.

DO YOU KNOW?

Over 86,000 women and girls are diagnosed with a gynecologic cancer each year.

The Women’s & Girls’ Cancer Alliance (WGCA) has been offering support and education on gynecologic cancer for women in Central Florida for nearly 20 years.

WGCA’s social support groups and Teal Mentor network helps patients and survivors relieve stress which helps in their recovery.

Most women don’t know that the Pap smear ONLY detects cervical cancer. It does not detect ovarian, uterine, vaginal, or vulvar cancer.
Florida Hospital Tampa Epilepsy Program Earns Designation as a Level 4 Epilepsy Center by the National Association of Epilepsy Centers (NAEC)

Level 4 epilepsy centers have the professional expertise and facilities to provide the highest-level medical and surgical evaluation and treatment for patients with complex epilepsy.

The Florida Comprehensive Epilepsy and Seizure Disorders Center at Florida Hospital Tampa has been recognized by the National Association of Epilepsy Centers (NAEC) as a Level 4 Epilepsy Center. The role of a specialized epilepsy center is to provide an accurate diagnosis of a patient’s seizure type and seizure syndrome, comprehensive epilepsy education for patients and their caregivers, appropriate treatment specific to a patient’s diagnosis and surgical treatment or access to it if indicated.

Epilepsy is a neurological disorder characterized by unpredictable seizures and can cause other health problems. It is the fourth most common neurological disorder in the U.S. and affects people of all ages. It is estimated that 1 in 100 people worldwide have epilepsy, which is why advanced centers such as Florida Hospital Tampa’s are so important.

“Being designated as a Level 4 Epilepsy Center is a testament to the incredible work done every day by the clinical teams here at Florida Hospital Tampa,” said Dr. Nancy Rodgers-Neame, Medical Director of the Neurodiagnostic Services Department at Florida Hospital Tampa. “We’ve spent years developing our epilepsy monitoring and treatment protocols, and that dedicated patient care has allowed us to provide comprehensive diagnostic and treatment services to individuals with uncontrolled seizures.”

Orlando Health Hospitals Awarded an “A” for Patient Safety Grade Underscores Successful Efforts to Enhance the Quality of Care Delivered Across the Organization

Four Orlando Health hospitals were recently honored with an “A” Hospital Safety Score by The Leapfrog Group, an independent national nonprofit run by employers and other large purchasers of health benefits. The hospitals are Orlando Regional Medical Center, Health Central Hospital, Dr. P. Phillips Hospital and South Seminole Hospital. South Lake Hospital, in affiliation with Orlando Health, received a “B” score. The scores were awarded based on a number of factors including the hospitals’ adherence to best practices in the process of providing care as well as rates for preventable medical errors, injuries, accidents, and infections. The scores reflect Orlando Health’s commitment to increasing the quality of care it delivers to all its patients.

“One of the most important elements involved in helping us achieve these great results is the development of something we call SAFE teams,” said Thomas Kelley, MD, Interim Chief of Quality and Clinical Transformation for Orlando Health.

SAFE is an acronym for Strategic Action for Excellence. Each Orlando Health hospital has a SAFE team that consists of a physician chief quality officer, a project leader who is typically a clinical professional, and up to a dozen additional team members who may be clinical or non-clinical. The teams use best practices, evidence-based medicine, and a variety of tools and methods to reduce or eliminate conditions or behaviors that could impede patient care. Improvements to change practice patterns in one hospital are shared across all Orlando Health facilities. The result is organization-wide standardization of care, which is good for patients.

“While we are extremely pleased with our grades this rating period, we continue to refine our processes and procedures regularly to further enhance the level of care we provide to our patients,” added Dr. Kelley.

“I am so very proud of our entire team,” said David Strong, president and CEO, Orlando Health, who joined the organization April 9, 2015. “Everyone in the organization has focused their collective and unwavering efforts on achieving the highest quality standards in the care and treatment of every patient who walks through our doors.”

To see how Orlando Health’s Leapfrog scores compare nationally and locally, visit the Hospital Safety Score website at www.hospitalsafetyscore.org.
Florida MD is a four-color monthly medical/business magazine for physicians in the Central Florida market.

Florida MD goes to physicians at their offices, in the thirteen-county area of Orange, Seminole, Volusia, Osceola, Polk, Flagler, Lake, Marion, Sumter, Hardee, Highlands, Hillsborough and Pasco counties. Cover stories spotlight extraordinary physicians affiliated with local clinics and hospitals. Special feature stories focus on new hospital programs or facilities, and other professional and healthcare related business topics. Local physician specialists and other professionals, affiliated with local businesses and organizations, write all other columns or articles about their respective specialty or profession. This local informative and interesting format is the main reason physicians take the time to read Florida MD.

It is hard to be aware of everything happening in the rapidly changing medical profession and doctors want to know more about new medical developments and technology, procedures, techniques, case studies, research, etc. in the different specialties. Especially when the information comes from a local physician specialist who they can call and discuss the column with or refer a patient. They also want to read about wealth management, financial issues, healthcare law, insurance issues and real estate opportunities. Again, they prefer it when that information comes from a local professional they can call and do business with. All advertisers have the opportunity to have a column or article related to their specialty or profession.

Please call 407.417.7400 for additional materials or information.
Florida Hospital is ranked the #1 hospital in the state of Florida for the second year in a row.

And ranked nationally in ten specialties.

We thank you for trusting us with your care. We thank our clinicians for their commitment to excellence.